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AUTHOR Culp, Wayne L.
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ABSTRACT

A practicum was designed to train school counselors in recognizing the signs of suicide, assessing suicidal ideation, and managing a suicidal crisis. It was also designed to develop in counselors a more definitive idea of their role in a suicidal crisis. The primary goal was to increase counselors' confidence in their ability to assess and intervene appropriately in potential or actual suicidal crises. Six 2-hour workshops on depression, consultation, recognizing the signs of suicide, assessing suicidal ideation, managing a suicidal crisis, drugs and lethality, and legal issues were planned and developed. Three other workshops, designed to fill in any remaining gaps, were also designed, and an evaluation component was developed and administered to workshop participants. Participants were 12 school counselors from one school system who worked with students in elementary and middle schools or with ninth graders in the high school. Analysis of data following the workshops revealed that participants had a more definitive idea of their role in suicide intervention, and that they had increased confidence in their ability to recognize the signs of suicide, to assess suicidal ideation, and to manage a suicidal crisis following workshop participation. All of the counselors attending the workshops indicated that the program had professional value to them and that they would like more programs of this nature. (Author/NB)

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PRACTICUM REPORT

Center for the
Advancement of Education
Ed.D. Program

A Training Program To Increase Elementary, Middle School, and Ninth Grade Counselors' Confidence In Suicide Crisis Intervention.

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NOVA UNIVERSITY

A Training Program To Increase Elementary, Middle School, And Ninth Grade Counselors' Confidence In Suicide Prevention And Suicide Crisis Intervention

by

Wayne L. Culp

Cluster 26-B

A Practicum I Report Presented to the Ed.D. Program in Early and Middle Childhood in Partial Fulfillment of the Requirements for the Degree of Doctor of Education

NOVA UNIVERSITY

1988

PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier:

Peter P. Damato

Peter P. Damato

School Psychologist
Title

1641 Derousse Avenue, Pennsauken, NJ
Address

May 24, 1988
Date

This practicum report was submitted by Wayne L. Culp under the direction of the advisor listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

6-23-88
Date of Final Approval of Report

Jo Ellen S. Rogers, Ph.D.
Jo Ellen Salce Rogers, Ph.D., Advisor

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ABSTRACT

A Training Program to Increase Elementary, Middle School, and Ninth Grade Counselors' Confidence in Suicide Prevention and Suicide Crisis Intervention. Culp, Wayne L., 1988: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: Suicide/Suicide Prevention/Suicide Crisis Intervention/Counselors/Counselor Training/Crisis Intervention/Counseling/Crisis Training for Counselors/School Counselors/Consultation Program/Consultants.

This practicum was designed to train school counselors in recognizing the signs of suicide, assessing suicidal ideation and managing a suicidal crisis. It was also designed to develop in counselors a more definitive idea of their role in a suicidal crisis. The primary goal was to increase counselors' confidence in their ability to assess and intervene appropriately in potential or actual suicidal crises.

The writer planned and developed a series of six 2 hour workshops on depression, consultation, recognizing the signs of suicide, assessing suicidal ideation, managing a suicidal crisis, drugs and lethality, and legal issues. Guest speakers addressed depression and assessment, consultation, drugs, and legal issues. The writer followed up with three workshops designed to fill in any remaining gaps -- employing discussion, tapes, and appropriate handouts. An evaluation component was developed and administered.

The practicum met all expectations. Analysis of the data revealed that participants had a more definitive idea of their role in suicide intervention, and that they had increased confidence in their ability to recognize the signs of suicide, to assess suicidal ideation, and to manage a suicidal crisis. All of the counselors indicated that the program had professional value to them and that they would like more programs of this nature.

CHAPTER I

INTRODUCTION

Description of Community

The community in which the writer works, and in which this practicum was implemented, is in the northeastern region of the United States. It is situated directly between a small, essentially urban city and a suburban middle to upper middle class residential township. It is also adjacent to a major city which has professional teams in all of the major sports, many well known museums and educational institutions, and all of the problems normally associated with a large city.

Until 2 years ago the community was officially classified by the state as suburban, but a changing population and changing socio-economic structure has resulted in a change of classification to urban. Until about 10 years ago the community was considered to be very stable and desirable. While there is still a stable segment present, the past few years have seen a great deal of movement -- both in and out. The community is viewed as a "stepping stone" to the good life in suburbia by many and as a step up by many more. As a result, there is much movement out of the small and large cities into the community by primarily members of minority groups and by whites who are members of the lower class. A large number, perhaps a majority, of those pupils moving in are from single parent families. The

movement out is mostly by whites.

The population of approximately 40,000 includes unskilled, semi-skilled, and skilled workers. It also is composed of a small percentage of those with professional training. From an economic viewpoint about 25 percent of the population would be considered to be in the upper-lower class, about 55 percent would be lower middle class, approximately 17 percent would be middle class and about 3 percent would belong to the upper middle class.

There is a large industrial base, including several large industrial parks, which helps the tax rate and also provides jobs for residents of this and surrounding communities.

The public school system is considered to be at least adequate by most and good by many. It consists of one comprehensive senior high school (grades 9-12), one middle school (grades 6-8) and nine elementary schools (preschool to grade 5), with a total student population of approximately 3,600. The school system meets or surpasses all state mandates and requirements and the high school is approved by the Middle States Association of Secondary Schools and Colleges. The high school also boasts of a band that is recognized and respected throughout the region and of sports teams that are highly respected statewide.

The Writer's Work Setting

The Writer is a member of the school system's Department of Special Services. The department is composed of counselors, speech

therapists, nurses, and child study team members, with one overall supervisor -- the director of special services. There are two elementary counselors (new positions created within the past two years), four middle school counselors and six counselors in the high school, plus a director of counseling services who also supervises the counselors. One counselor in the high school and one in the middle school are assigned special education students only.

The department also includes four speech therapists, one speech and language pathologist, and six school nurses. The professionals have assignments throughout the school system.

Specifically, the writer is a school psychologist on a multi-discipline child study team. There are four teams in the department and each team is composed of a psychologist, a school social worker, and a learning disabilities teacher/consultant. Each team employs the case manager approach to team business -- there is no official chairperson. The case manager assigned to a student assumes the chairperson's role at any meetings associated with that particular student.

The child study section of the staff is unique in that it has a special prevention/intervention mission -- rather than being assigned diagnostic duties only. Some of the special projects, each staff member has one, will reflect both our mission and the nature of the populations we serve. Special projects include suicide prevention and awareness, child abuse and neglect, teenage pregnancy, student assistance for substance abuse, and occupational therapy. In keeping with new state proposals, which are not yet official, we serve special

education and regular education students alike, as needed.

The Writer's Role and Responsibilities

The writer is currently assigned from preschool through grade 12 with special emphasis on the middle and high schools. While his primary employment is that of school psychologist, he is also a licensed psychologist in another state where he is currently working to develop a part-time private practice. Past experience includes 5 years as a science teacher, 12 years as a high school counselor, and 7 years as a school psychologist.

As the "Suicide Awareness Person" for the school system, it is suicide prevention and crisis intervention which has occupied much of the writer's professional time for the past 3 years. In this capacity, he has planned and conducted suicide prevention workshops for the entire staff and has also performed many crisis interventions. He has also conducted similar workshops for other school systems and professional counselor groups. Regular duties include diagnostic evaluations, counseling, consulting, crisis intervention, and case manager functions.

In the past the writer has conducted group counseling and affective education groups for high school and elementary students. This includes groups on death and dying, divorce and separation, and human relations. He has special training in the Human Development Program (magic circle), values clarification, and as a Parent Effectiveness Training (PET) instructor. He has conducted workshops

for teachers and administrators in communications, conflict resolution, suicide prevention, and human relations.

The writer has an undergraduate degree in biology, a Master's degree in pupil personnel services and is certified in school psychology. Post graduate work has emphasized psychology, affective education and cognitive-behavioral therapy. Suicide prevention and cognitive behavior therapy are his current areas of greatest professional interest.

Previously, the writer has supervised student teachers and school psychology externs.

CHAPTER II

STUDY OF THE PROBLEM

Description of the Problem

Four years ago a student in the middle school in which the writer works shot and killed herself with a pistol. This happened despite at least 20 documented contacts by the girl's counselor and school psychologist -- not the writer -- with both the student and her mother. The girl shot herself the very next day after the counselor and psychologist met with the mother and pleaded with her to consult an outside therapist -- due to her daughter's suicidal ideation. Even though her mother promised to contact one of the several therapists given to her in writing, she never did. And even though involved professionals did what they were supposed to do, incredibly, the girl's mother filed a lawsuit for negligence against the school system. When, after 3 years, the case was finally reviewed by a judge, it was dismissed immediately due to lack of any evidence for negligence.

However, prior to the case being dismissed, the suicide set off a chain of events which, in part, led to this practicum. Within 3 months the writer was asked to become the "suicide specialist" for the system and was made responsible for suicide awareness and prevention. In this capacity the writer conducted suicide awareness workshops for the entire professional staff. These workshops centered around learning to recognize common signs of suicide. The writer also formulated a

policy and set of procedures on suicide intervention to guide the appropriate professionals -- counselors, psychologists, and social workers. The policy was adopted by the district and large parts of it eventually were used as an example of a model policy by the state administrators' association.

These actions were followed with small group meetings with the counselors. The counselors were asked to review appropriate literature and the school policy, which had been disseminated previously. These topics were then discussed in meetings led by the writer. Basically, it was believed that the counselor should be able to determine which cases were less serious and that they would intervene in the majority of cases themselves without involving the child study team. Essentially the policy (See Appendix A) calls for the counselor to make referrals to outside professionals whenever a student expresses suicidal ideation. It is understood that in cases of imminent danger, or when the signs are less clear, then support from a member of the child study team would definitely be appropriate. The overriding implication was believed to be that intervention in this difficult problem should be a team effort generally, but that there were situations in which specific members would perform specific tasks themselves.

Despite these actions there are still, throughout the school system, large numbers of referrals for assessment of suicidal potential and/or suicidal crisis intervention -- from the counselors to child study team personnel. This includes referrals from the elementary schools which, although significant, are far fewer in number than from the middle and

high schools. The psychologists and social workers on the child study team often and increasingly, feel overburdened by the large number of referrals for intervention. They often feel that the district's counselors should assume more, not total but more, responsibility in this process.

However, it appears that the counselors lack confidence in their ability to properly assess and intervene in potential and/or actual suicidal crises. This is in spite of the fact they are, generally, very capable and confident in performing other expected duties and responsibilities. The established policy and procedures go largely unheeded. It seems that in a crisis the first impulse of the counselors is to call the school psychologist.

Briefly stated then, the problem was that counselors appeared to lack confidence in their ability to recognize the signs of suicidal potential and to intervene appropriately.

Documentation of the Problem

In order to document that youth suicide is a serious problem, the literature was reviewed and will be reported in an upcoming section of this proposal. Specifically, in order to document that a problem definitely existed in the writer's work setting, several simple but, yet, revealing steps were taken. First, in November, 1987, the psychologists and social workers on the child study teams were surveyed by the writer. On an individual basis, each was asked to report the specific number of referrals, by counselors to them, from the previous

(1986-87) school year. The results were totaled and are as follows: 38 referrals from the high school, 25 from the middle school and 21 from the nine elementary schools. Fortunately, approximately a third of these cases were reported to be not serious, but the point is that intervention and assessments were required and that these actions are very time consuming. Approximately a third were considered serious encough to require immediate referrals to private therapists or mental health agencies, while the remaining third was judged to require attention by an outside counselor or therapist -- but not necessarily immediate attention.

Also in November, 1987, the psychologists and social workers were surveyed individually as to whether or not they believe that counselors follow the procedures established by school district policy on these matters. It is important to note that no reason, other than information-seeking for a graduate school "report" was given for the request. All stated that counselors do not routinely adhere to the procedures established by the policy. They believe that the system's counselors almost always call for help when, according to the policy, they should not need to call. This is especially true in cases where suicidal ideation is evident and clearly expressed. In these cases the policy calls for a direct referral to an outside mental health professional and there is no need for a school psychologist or social worker to intervene. Still the counselors seem to feel a need for the presence and support of a child study team member.

Analysis of the Problem

It is likely that the problem expressed in this practicum -- that counselors appear to lack confidence in their ability to intervene appropriately with potential suicidal students -- has many causes. One distinct possibility is that they still might not really be familiar with and understand the district's suicide policy and set of established procedures. They may view the policy as just one more of the many pieces of paper to come upon their desks. It may be viewed as something to file or "deep six." While it is not believed that they take lightly the subject of suicide, they still might need to concentrate harder on understanding the policy.

Also, they may not recognize or be confident in their ability to recognize, the "signs of suicide." Examples of a sign would be a dramatic change in a student's behavior, or a drastic change in eating habits. While most, but not all, have participated in workshops in which the signs were emphasized, this is not a task which they perform on a daily basis and this may undermine their confidence.

The counselors' lack of experience in dealing with suicide assessment and crisis intervention may also undermine their confidence levels. On one hand the direct result of making an immediate call to the school psychologist precludes the counselor's acquiring ability and experience in handling a case of this nature. For example, when the writer was a school counselor there was only one school psychologist in the entire district. He was so busy that the counselors never called him. Consequently the writer received a great deal of experience in

this area and was viewed as a logical choice to become the district's specialist when the need arose. The current crop of counselors is not receiving this experience. On the other hand four of the counselors have not had a chance to acquire a backlog of experience because they have been counselors for less than 4 years.

When drugs are involved, or are used directly in a suicide attempt, the counselors probably are not thoroughly familiar with specific drugs nor do they likely to know what constitutes a lethal dose. They have had short presentations, in the past, on drugs in general but have not as a group studied drug lethality.

Another factor in the problem may be concern or worry about the legal ramifications of involvement in cases of this nature. The writer, as one who deals with the counselors on a daily basis, can attest to their concern -- especially in light of their colleagues' experiences with the eighth grade girl who committed suicide.

Lack of specific training in assessing the seriousness of suicidal signs and suicidal intent appears to be a major factor in this problem. The same can be said of their training in suicide crisis intervention. When polled individually, only one of the counselors stated that they had ever had specific training in these areas -- other than the workshop conducted by the writer on recognizing the signs of suicide. None had training in their respective graduate schools.

An overriding, or general, factor might be that the counselors are not clear, for several or all of the reasons mentioned above, as to exactly what their role is in these cases. Also, in crisis intervention,

the counselor really serves as a consultant. It is interesting to note that another individual survey, of the counselors by the writer, revealed that none had specific training in consulting skills.

The Relationship of the Problem to the Literature

In order to help solve the problem of increasing counselors' confidence in their ability to intervene appropriately in potential youth suicides, the literature was reviewed.

The review of the literature on youth suicide will include an explanation of the significance of the problem, a description of various components of the problem, and a discussion of each of the components and how they are related.

The significance of the youth suicide problem has been documented by Farberow (1985). Suicide in the age group 15-24 has increased by 119 percent between 1965 and 1978; a young person commits suicide every 90 minutes; approximately 6,000 young adults and adolescents take their own lives each year; suicide is the third leading cause of death in this age group. The most substantial increases in completed suicides have been in the white male population and suicide is the number one killer in the Native American population. The rate for black males peaks between the ages of 25-34 and between the ages of 20-29 is almost the same as the rate for white males.

Faberow (1985) also states that the surge in suicide rates has not been limited to the United States. Canada has reported on even larger increase in the suicide rates of its young, mostly white, males, as

have a number of European countries. These countries include Finland, Austria and West Germany, with Finland showing the greatest increase in its young males, more than tripling to 211 percent. The youth suicide rates in France have climbed steadily since 1965 and Sweden's rates peaked in the mid-1970's before decreasing to their original level. In the Far East, the rate in Japan rose markedly in the 1970's and then dropped considerably. In Australia the rates for both males and females in the younger age group rose markedly in the late 1970's and then began to drop slightly.

In addition to the facts reported above and more facts to come, the other components of this issue include causes and factors contributing to the increase in suicide rates, suicide prevention -- including recognizing the signs of suicide -- for educators, other professionals, parents and children, effective intervention, and treatment of those with suicidal ideation. This review will not consider treatment because this goes beyond the scope of the writer's current proposal. However, the review will cover the first three issues cited in this paragraph in addition to the literature on counselor training in suicide crisis intervention.

Additional facts reported by Jensen (1984) will reinforce the severity of the problem: (1) Suicide is the second leading cause of death in young people between the ages of 10 and 24; (2) the rate of adolescent suicide has tripled since 1960; (3) 85 percent of all adolescents think about suicide at some time; 50 percent of these seriously consider suicide as a means of resolving their problems; (4) 80 percent

of those who kill themselves have made overt threats beforehand; (5) there is no stereotype of the suicidal person; (6) suicidal people cannot normally be labeled "psychotic" or "insane." While it is common for those who attempt suicide to feel hopeless and depressed, they do not necessarily suffer from serious mental illness.

Between the ages of 8 and 14, suicide is the eighth leading cause of death (Steele, 1985). In New Jersey there is a definite increase in the number of suicides in the 5 to 14 age category, and this appears to be a national trend (New Jersey Department of Education [NJDE], 1984). The National Institute of Mental Health has noted an increase in childhood and early adolescent suicide. Also, all of the suicides in the 5-14 age group in 1981 were male. The data suggest that young pre-adolescent and adolescent males appear to be more vulnerable to death by suicide than is the case in the recent past. This is apparent for both white and non-white males.

Annually there are 35,000 suicides reported in this country. However, this is considered a misrepresentation since many suicides are covered up by parents and medical examiners in order to spare survivors the emotional stigma of suicide that continues to persist. Many suicides are reported as accidental or undetermined deaths. It is suspected that many automobile accidents, often those involving intoxicated victims, are in fact suicidal. Therefore, a more realistic estimate is that approximately 100,000 people kill themselves annually (Steele, 1985). It has been noted that in the 15-24 age group accidents are the leading cause of death (Allison-Tomlinson, 1981).

Youth suicides occur most often within the home between the hours of 3:00 p.m. and midnight in the Spring and Summer months. There is another peak in the Fall with an increase around the December holidays (McLeod, 1987).

Dempsey (1986) reports that numerous myths have developed over the years about suicide and the suicidal person.

1. *Myth: Those who openly talk about suicide never commit it.*

   Fact: There has long been a tragic belief that those who threaten suicide never follow through with the act. Research indicates that as many as 60 percent of those who commit suicide have made statements about their intentions to someone. Verbal threats or even reference to suicide should be construed as a cry for help. Adolescents who openly discuss the alternative of suicide may be asking for intervention. If the cry for help is not heard, or, if heard is not treated seriously, the outcome may be tragic.

2. *Myth: There are suicidal-type people.*

   Fact: Suicide knows no racial, sexual, economic, social, mental, physical, or biological restrictions. The death of a parent by suicide can increase the potential for self-destruction by an adolescent. If that parent is viewed as a positive role model by the youth, the adult's solution can then become the adolescent's solution. Generally speaking, however, death by suicide cannot be "type-cast."

3. *Myth: Suicidal people are completely intent on dying.*

   Fact: Most people who attempt or commit suicide are undecided about whether or not to continue to live. They tend to gamble with death, trusting and hoping that others will help them. Nearly no one commits suicide who has not told others in some fashion how he or she is feeling.

4. *Myth: Once a person becomes suicidal, he or she is suicidal forever.*

   Fact: Research tells us that people who consider self-destruction are in that state for only limited periods of time. This does not mean that this state cannot periodically recur when the individual's perceptions of life become clouded. But if the person receives help when it is needed, there is good reason to believe that suicide as a solution can be removed from the person's alternatives.

5. *Myth: Improvement after a suicidal crisis or attempt means the risk is over.*

   Fact: The turmoil of an attempted suicide can be devastating to an individual, usually creating emotional exhaustion. Research indicates that most suicides occur within about three months after the signs of recovery from an attempted suicide have been observed. It is at this point that the individual usually has sufficient energy to put suicidal thoughts back into action.

6. *Myth: Suicide victims are always mentally ill or psychotic.*

   Fact: Studies of hundreds of genuine suicide notes indicate that suicidal people are extremely unhappy and not necessarily mentally ill. They are suffering from a complex set of forces that manifests itself in seemingly hopeless dependency -- a feeling that joy and optimism are not obtainable and that life is not worth the continued hassle.

7. *Myth: Suicide happens without warning.*

   Fact: In most cases, many clues are given that might alert friends and family to the possibility of an impulsive act. It is extremely important that we are attuned to these clues. One of the most obvious indicators of potential basis for suicidal behavior is a rapid change or drastic alteration in one's moods, ambition, interests, involvements, and, in general, a change in lifestyle.

8. *Myth: Inquiring about suicide plans will increase the likelihood of a suicide.*

   Fact: Asking about suicidal thoughts in depressed persons does not increase the risk of suicide. It is important to determine the person's intent. To discuss these plans openly and honestly can do much to put the problems into focus.

An additional myth is discussed by Capuzzi (1986).

Myth: Suicide is hereditary.

Fact: Suicide is not genetically inherited. However, it does tend to run in families. The suicide of one family member tends to increase the risk that suicide will be viewed as an appropriate way to solve a problem.

Other myths are reported by the New Jersey department of Education (1984).

Myth: There is a low correlation between alcoholism and suicide.

Fact: Alcoholism and suicide often go hand in hand.

Myth: Suicide is basically a problem limited to those who are relatively young.

Fact: Suicide rates rise with age and reach their peak among the elderly.

The causes of youth suicide are diverse, extensive, and uncertain. Yet there appears to be some consensus as to the basic causes (Allison-Tomlinson, 1981). Suicidal acts seem to be either the result of a sudden impulsive reaction to a precipitating stressful situation or the result of numerous sociopsychological factors that have influenced the victim's behavior for a long time. Environmental factors appear to play a major role. The factors might include lack of parental love, parental authoritarian attitudes, family conflict, low socioeconomic status, loneliness, and parental/youth alcoholism.

Others suggest that loss of a love object, stress, identity problems, and identification with a deceased loved one are contributing

factors. Interpersonal relationships can play a major role in suicide. Often there is a fundamental disturbance in communication between parent and child. Adolescents with suicidal tendencies are more likely to have a history of family conflict and disorganization. Additionally, those youth with suicidal tendencies had been exposed to suicide in family member or acquaintances and had feelings of a lack of control over their environment (Alison-Tomlinson, 1981).

The best protection for suicide may be a close, caring, considerate family. The family appears to be the key element in preventing suicide. Loving, concerned parents and relatives may be the best insurance (Changing Times, 1982).

Peck (1980) says that 75 percent of suicidal adolescents have a poor relationship with parents and 90 percent feel that parents do not understand them. Adolescents often find themselves caught in a conflict of loyalties between parents and/or siblings, pressured to take sides (Joan, 1986).

Other factors are (1) increased pressure not to fail; (2) more hassles involved with being young; (3) disillusionment with planning a career; (4) sexual victimization; (5) battering or child abuse (Joan, 1986); (6) overprotected or perfectionistic children who are afraid to make mistakes and are not able to cope when they do (Changing Times, 1982); (7) experiencing prenatal respiratory distress, no antenatal care before 20 weeks of pregnancy, and chronic disease of the mother during pregnancy (Greenberg, 1985); and (8) television programs which solve life problems in 30 minutes or less (McLeod, 1987).

McLeod (1987) believes that the climate of society today is violent and anti-child. Abortion, child abuse, child kidnapping, and child murder are not uncommon. "Kiddie Porn" is currently big business. The threat of nuclear war is an overriding concern to most. Common also are: (1) the myth that dead is not irreversible (2) anomie -- a loss of relatedness; and (3) a sense of powerlessness (Slaby and McGuire, 1986). Carlson, (1983) states that he has never seen a suicidal prepubertal child that did not have severe family problems.

Whatever the causes, Shneidman (1985) believes that pain is what the suicidal person is seeking to escape. Suicide is best understood as a combined movement toward cessation of consciousness and as a movement away from intolerable emotion, unendurable pain, and unacceptable anguish. The wish or need to effect a cessation of consciousness is because of the pain. No one commits suicide out of joy; no suicide is born from exultation.

One of the most useful ways to view suicidal behavior is to think of it in terms of a drastic form of communication. Those who have consistently failed to communicate effectively through normal channels may resort to self-destructive activities as a last ditch effort to communicate with the outside world. By so doing they may bring attention to their plight and ultimately receive assistance (Miller, 1985).

The ultimate prevention of suicide is through public education about the clues to suicide. Primary prevention is the best prevention and the primary prevention of suicide lies in education. The public

needs to know that there are verbal and behavioral clues that can be looked for and that help is available (Shneidman, 1985).

The following list includes some of the major warning signs that those contemplating suicide give us (McLeod, 1987):

1. Most important warning of suicidal ideas is a suicide attempt; always take it seriously. Never dismiss it as a ploy to get attention; it may be that, but it still needs to be addressed. While depression does not always accompany suicidal behavior, it often does -- look for depressive equivalents.
2. Disturbed sleeping habits -- too much or too little -- waking in the middle of the night for long periods or early in the morning. Inability to get up and face the day.
3. Changes in eating habits -- too much (bulimia) or too little (anorexia) food.
4. Giving away treasured possessions.
5. Preoccupation with death in art, music, personal journals.
6. Verbal comments -- "I wish I were dead," "You'd be better off without me," "I want togo to sleep and never wake up."
7. Taking life-threatening risks or getting into frequent accidents.
8. Changes in study habits -- lowered grades.
9. Apathy -- inability to enjoy things previously enjoyed.
10. Involvement in drugs, alcohol or sexual promiscuity for a formerly conscientious adolescent.
11. Do not underestimate depression in the thoughtful, well-behaved "perfect child." While this child does not attract attention

as does the acting out youth, he may be just as depressed because of a failure to meet self-imposed expectations that destroy his self-image.

12. Psychosomatic symptoms -- headaches, stomachaches, etc.

Miller (1985) lists the best collection of examples of verbal warnings that the writer has seen. They are: (1) "I've decided to kill myself." (2) "I've had it; I'm through." (3) "I wish I were dead." (4) "I'm not the man I used to be." (5) "I've lived long enough." (6) "I'm calling it quits --- living is useless." (7) "I hate my life. I hate everyone and everything." (8) "It was good at times, but we must all say goodbye." (9) "The only way out is for me to die." (10) "I just can't go on any longer." (11) "You won't be seeing me around anymore." (12) "Do you believe in reincarnation? I'd like to come back someday. Maybe things will be better then." (13) "If I don't see you again, thanks for everything." (14) "You're going to regret how you've treated me." (15) "It's too much to put up with." (16) "Life has lost its meaning for me." (17) "Nobody needs me anymore." (18) "I've been seriously thinking of making out my will." (said by a 24-year-old pregnant woman with two children). (20) "I'm getting out; I'm tired of life." (21) "Ever since I retired, I've felt like I was in the way all the time." (2) "Do you know the procedure for donating your eyes after death?" (23) "How do they preserve your kidneys for transplantation if you die suddenly?" (24) "I wish I could tell you how important you've been. You've helped me

to see things clearly. Now I know the only road that's open for me." (25) "Life is like a short circuit. There's a sputter, then the lights go out." (26) "If (such and such) happens, I'll kill myself." (27) "If (such and such) doesn't happen, I'll kill myself." (28) "You know, son, I'm going home soon." (29) "Here, take this (cherished possession); I won't be needing it anymore."

The major sign of suicide and often the one which is an overlay of the other signs is depression. While depression is not always a factor in suicide at least two-thirds of those who kill themselves suffer from depression (McLeod, 1987). Some of the major signs of depression are: obvious unhappiness, withdrawal and isolation, feelings of helplessness, worthlessness or hopelessness, unusual fatigue of lethargy, self-neglect, pre-occupation with sad or negative thoughts, inability to concentrate, lack of interest in immediate surroundings, physical complaints; hypochondria, insomnia or excessive sleeping, appetite disorders; excessive eating or dieting, sexual disorders, fear of insanity or nervous breakdown.

Sometimes depression will be manifested by active defiance rather than passive neglect. These "acting-out" behaviors, or "masked" symptoms of depression, are extremely common among youths. They may appear in addition to, or in lieu of, other more widely recognized symptoms of depression listed herein: Defiance, rebellion, disobedience, truancy, delinquency, running away, drug abuse, academic or social failure, sexual promiscuity (Allen, 1986)

Konopka (1983) suggests other means of preventing suicide. She

believes that it is most important for adults to listen to what our youth have to say and to take them seriously. Adults must make time for them and respect them as people. We should share ideas, values, and opinions with them and stop assuming that the generation gap is a "given." We should not be afraid to show love and a sense of caring. We also need to prepare them for the inevitable pain that is often present in life. We should offer open communication, loving respect, provision of creative outlets, acceptance of strong emotions, and allowance for laughter and tears.

Thus far the writer has reported a review of the literature on suicide, especially as related to youth suicide. The significance of the problem was reviewed and then facts, causes, factors and signs of suicide were considered. All of these are important and necessary to the school counselors who may be attempting to develop professional skills in this area. However, there are other skills which counselors need to develop and they are: (1) the ability to assess the seriousness of suicidal intent and (2) the ability to intervene in a suicidal crisis and to manage it effectively. The writer and others (Schmidt & Medl, 1983) view crisis intervention as falling under the "umbrella" of counselor as consultant.

Consultation is an intervention strategy that is often used by counselors but is seldom well understood (Male, 1982). A consultant provides an indirect service to students through direct service to teachers, parents, or the entire school. Thus work with one teacher can impact on 25-30 students in a year and possibly thousands of students

during a teacher's career (Umansky & Holloway, 1984).

According to Male (1982) consultation is a second order intervention involving a relationship between a professional helper (consultant), a client (consultee), and a help-needing system (target). The relationship is normally viewed as temporary by all parties involved. In its present form the target does not directly engage the services of the consultant -- the consultee enlists the help of the consultant in order to bring about change in the target system which may or may not include the consultee. Schmidt & Medl (1983) describe the process as a triangular relationship that, in the schools and in crisis interventions, often finds both counseling and consulting useful in the same situation.

The consultation process is best carried out in a series of sequential steps (Male, 1982):

1. *Initial contact and agreement;*
2. *Defining the relationship and data gathering;*
3. *Diagnosis and development of objectives;*
4. *Generation and selection on intervention strategies;*
5. *Implementation;*
6. *Providing support for and evaluation of attempted solutions;*
7. *Termination and follow up.*

Dinkmeyer & Dinkmeyer (1984) indicate that the best use of consultation is primary prevention of problems. They caution against using strictly a problem solving approach to consultation. A problem oriented approach can limit counselors to a "firehouse" orientation.

None of the steps in the consulting process are absolutes or mutually exclusive. Counselors may find that they need to return to earlier steps for more information. In crisis cases a consultant might move through all the steps in a matter of minutes or even seconds. However, even in crisis situations the steps can be mentally processed by school counselors and provide structure to the helping process (Schmidt & Medl, 1983).

Related to consultation, an important role that counselors should be able to play is that of crisis interventionist. According to Miller (1985), an interventionist does not have an ongoing relationship with a suicidal person as a therapist would. The interventionist's task is to keep a suicidal person alive long enough to link him/her with a therapist. Further, an interventionist is one who can: (1) recognize the early warning signals of suicidal risk, (2) evaluate various risk factors present in the person's life to determine the degree and immediacy of the risk, and (3) make an effective referral to an appropriate resource in the community. After taking these steps the interventionist quickly extricates himself/herself from the situation.

Capuzzi (1986) explained that in crisis management the word <u>*crisis*</u> *means not normal or usual because the young person in question is self-destructive. The word* <u>*management*</u> *means that for a short period of time the client must be directed and monitored. Definite steps must be taken to safeguard the client's life and these steps must be explicated in an assertive, direct manner while conveying concern and empathy. Miller (1985) believes that the suicidal person is confused*

and is searching for a strong, authoritative figure to direct his/her emotional traffic. It is imperative that the interventionist quickly assure the suicidal person that assistance will be rendered.

Specifically when evidence of suicide ideation is present but the act is not imminent, three elements require investigation: specificity of details, lethality of method, and availability of means (Martin & Dixon, 1986). It is essential to remember that most people are suicidal for only a short period of time, usually a matter of days, and often change their minds about taking their own lives; the goal of crisis intervention is getting people to postpone irreversible decisions until other help can be brought to bear on the situation (Slaikeu, 1980).

In assessing the risk of suicide several major factors or principles should be considered:

1. *The first need is to determine whether or not the client will admit to being at risk for suicide. The question (or one similar to it) "Have you been thinking about harming yourself?" should be asked.*
2. *Do not be afraid to ask the above question. Mentioning the word <u>suicide</u> will not cause anyone to perform the act. (Miller, 1985)*
3. *The next step is to determine if a plan exists (Slaikeu, 1984). This is the beginning of the process involved in assessing the degree of risk. Without a plan the client is less likely to make an attempt. Next, the need is to determine lethality. In this context lethality*

is a measure of how quickly death could be accomplished. Also to be assessed is the availability of the proposed means (Miller, 1985). Drugs and guns are prime examples of highly lethal means.

4. *A history of previous attempts is an important consideration (Slaikeu, 1984). A history of previous attempts puts one at higher risk. The probability of success increases with each attempt.*
5. *The willingness to make use of outside resources is also a necessary criteria to assess. Are there people nearby who care about this person? The greater the distance from those who could rescue him/her the greater the degree of risk (Miller, 1985). It is also important to ask the client if he/she will call on these others. Those who cannot give assurance that they will need to be treated differently -- possibly hospitalized (Slaikeu, 1984).*
6. *Many (Capuzzi, 1986; Fujimura, Weis & Cochron, 1985; Martin & Dixon, 1986; Miller, 1985; Slaikeu, 1984) have reported the positive influence of having the client sign a written contract. Basically the client agrees not to kill himself and to make it alive to the next day and/or next appointment.*

Although the most reliable information is gathered during the interview, the counselor may use one of several depression and/or suicidal intent scales to assist in determining the degree of risk.

One such scale is Beck's Suicidal Intent Scale which focuses on circumstances surrounding the suicide attempt (Martin & Dixon, 1986).

When a referral has been made, follow up of the case is of utmost importance. The counselor should determine whether or not the client has in fact made an appointment with the referral agent. Support is necessary until this contact is made. When a student returns to school the counselor should meet with him/her to demonstrate concern and caring (Capuzzi, 1986; Slaikeu, 1984).

The legal issue is an important one to counselors. Liability usually arises as a result of the counselor either (1) failing to act in a way to prevent the suicide or (2) doing something that directly contributed to the client's suicide. The key question concerns foreseeability. Did the counselor know or should he or she have known of the foreseeable risk? Malpractice suits are based on a counselor being grossly negligent and not necessarily upon making a wrong decision or mistake. In order to decrease the incidence of malpractice suits it is recommended that the counselor: (1) know when and how to appropriately refer clients whose problems go beyond their level of expertise and (2) undergo training for suicide prevention and intervention (Fujimura et al., 1985)

Although the need for training has been cited by several writers in the field (Fujimura et al., 1985; Slaikeu, 1984; Capuzzi, 1986; Engen, 1977; Umansky & Holloway, 1984) there is a paucity of literature on specific training programs for counselors in the schools concerning suicide prevention and suicide crisis intervention.

Umansky and Holloway (1984) have reported that confusion about the counselors' role in the consultation process may be due to the counselors' lack of training. According to Engen (1977), while there is an ever growing need for new knowledge and skills, there seems to be few organized efforts to meet these needs. In his study of counselors' training needs in Iowa, 75 percent of the counselors indicated a need for training in counseling, consulting, clinical information and drug abuse. These needs may have developed because few counselor education programs include training in these areas. Furthermore, new counselors are narrowly trained in role conception, are uninformed of new practices and developments, are not helped to work with other school personnel, and have no training in intervention services. There is a gap between the training counselors receive and the realities of current practice. School counselors are desperate for help in these times of upheaval and confusion. While Engen wrote on this subject 10 years ago, it is the writer's experience that very little has changed since that time.

The sparcity of literature on training programs for counselors, reported previously, may be because: (1) there are few programs in operation or (2) because the training is not being done by college professors who write journal articles or (3) both of these and/or other factors beyond the writer's knowledge. One other possibility, based on the writer's experience, is that counselors participate in isolated presentations on specific aspects of crisis intervention, rather than having the opportunity to receive training in a series of coordinated training sessions.

The best report of a training model for school personnel in the literature was one conducted by a New Jersey group (Heiman, Jones, Lamb, Dunne-Maxim, and Sutton, 1985). Concern was expressed about the ability of schools to manage suicidal crises once consciousness has been raised. Schools need to know what to do and how to respond to at-risk students. Concrete policies, organizational strategies and skilled internal resources are needed within a school to maximize prevention efforts.

A program was developed for school psychologists, social workers, nurses and counselors to train them in assessment and crisis intervention. According to the developers, several key factors need to be considered in creating effective school programs: (1) It is important for training to focus on demystifying the intervention process. As school staff begin to view assessment and intervention as a skill which can be acquired, they become more confident in their ability to be effective. (2) An eight week on-site course was found most effective. Participants were encouraged to seek a second opinion when they are unsure about a client. (3) School personnel experience the greatest anxiety over contacting and working with families. However, this is an important role for school staff members. (4) Learning to directly ask students if they are suicidal is also very anxiety provoking (Heiman et al., 1985).

Another program in California, for teachers and counselors concentrated specifically on producing an understanding of the basic facts and concepts of suicidal crises, ways in which school personnel could identify presuicidal behavior, and ways in which they could

respond effectively in such situations (Ross, 1980). Training kits, including selected readings, bibliographies and guidelines were developed. The concept that asking and talking about suicidal feelings as the single most helpful thing that a potential resource person could offer was a predominant theme in most of the training sessions. Providing the participants with facts -- and their own school regulations -- did much to reduce their anxieties. Giving them the information they needed in order to respond meaningfully was clearly effective in instilling the confidence to do so.

To summarize, the writer has reported a review of the literature on suicide and youth suicide. The facts presented demonstrated the seriousness of the problem. The discussion of the causes revealed that the problem is a complex one. Verbal and nonverbal signs of suicidal intent were listed and their importance in suicide prevention was emphasized. Assessment techniques and major principles of suicide crisis intervention were reviewed -- as related to a consultation model. The need for training counselors in these methods was discussed in conjunction with specific training models that were reported to be effective.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

In order to increase elementary, middle school, and ninth grade counselors' confidence in suicide prevention and suicide crisis intervention, a training program was developed. The major goal of this program was that counselors would be able to demonstrate increased confidence in their ability to assess and intervene appropriately in potential or actual suicidal crises.

Behavioral Expectations

The first objective addressed the issue of role confusion among counselors who are involved in suicide crisis intervention. Counselors often do not clearly understand their roles in situations of this nature. The second objective addressed the importance of recognizing the signs of suicide. This was established by the literature as being of primary importance to counselors. The third objective dealt with the problem of assessing the seriousness of suicidal intent when signs are evident -- established in the literature as a major skill for counselors to possess. The fourth objective concerned counselors' confidence in their ability to intervene in a crisis -- to do "the right things." Based on these concerns, the following behavioral objectives were selected for this practicum:

1. Over a period of 12 weeks, counselors will develop a more definitive idea as to their role in suicide crisis intervention.

2. Over a period of 12 weeks, counselors' confidence in their ability to recognize the signs of suicide will increase.

3. Over a period of 12 weeks, there will be an increase in counselors' confidence to assess suicidal potential when signs are evident.

4. Over a period of 12 weeks, counselors' confidence in their ability to intervene in and manage a crisis situation will increase.

Standard of Performance

The following standards of performance were used to measure the behavioral expectations:

1. At the end of the 12-week period, at least 50 percent of the counselors will indicate that they have a clearer idea as to their role in suicide crisis intervention.

2. At the end of the 12-week period, at least 50 percent of the counselors will indicate that they have more confidence in their ability to recognize the signs of suicide.

3. At the end of the 12-week period, at least 50 percent of the counselors will indicate more confidence in their ability to assess the seriousness of suicidal ideation.

4. *At the end of the 12-week period, at least 50 percent of the counselors will indicate more confidence in their ability to manage a suicide crisis.*

Assessment Instruments

Each objective of the training program was assessed as follows in order to measure the standards of performance:

1. *The evaluation tool was a question on a post implementation questionnaire consisting of yes or no responses (see Appendix B).*

2. *The evaluation tool was a question on a post implementation questionnaire consisting of yes or no responses (see Appendix B).*

3. *The evaluation tool was a question on a post implementation questionnaire consisting of yes or no responses (see Appendix B).*

4. *The evaluation tool was a question on a post implementation questionnaire consisting of yes or no responses (see Appendix B).*

Each objective was addressed by a specific question on the written questionnaire -- questions eliciting yes or no responses. However, other "yes" or "no" questions related to the objective were also be included in order to provide more depth of understanding. The questionnaire included open-ended questions aimed at getting the participants to evaluate the program in general (see Appendix B).

No time limit was imposed.

The writer realized that during implementation, unexpected events often occur. A log was kept in order to record these events should they appear.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

As reported in Chapter II, the literature on specific training programs for school counselors is scarce indeed. The writer's manual, journal by journal, search through the past 5 years of two of the best known counseling journals did not reveal a single study on this topic -- the journals were The School Counselor and The Journal of Counseling and Development. Neither did the literature review reveal any studies of school psychologists, in positions similar to that of the writer's, being concerned about or dealing with counselor training for suicide crisis intervention. The training programs which were reviewed were developed and conducted by outside specialists (Heiman el al., 1985; Ross, 1980).

However, the literature did clearly suggest elements, or topics, which should be included in programs dealing with suicide and suicide intervention. It is evident that most suicide programs and journal articles on suicide, begin with facts and statistics. Farberow (1985), Jensen (1984), Steele (1985), and Allison-Tomlinson (1981) provided the statistics to establish the significance of the problem. These statistics would be an excellent introduction to a workshop on suicide.

There is also a need to understand the causes of suicide in this

society. Peck (1980), Slaby and McGuire (1986), Carlson (1983) and Shneidman (1985) nicely reviewed societal, familial and other causative and/or contributing factors.

Shneidman (1985) was one of many to address the importance of being familiar with the clues, or signs, of suicide -- given to us by those contemplating suicide. Initial training sessions in suicide prevention usually emphasize these verbal and behavioral clues. Shneidman, one of the foremost suicideologists in the United States, believes that primary prevention is the best prevention and that primary prevention comes through education. It is especially important to understand depression, and its key signs, which are often major factors in suicidal ideation (Allen, 1986; McLeod, 1987).

Male (1982) emphasized the role of counselor as consultant and explained that this often involves providing indirect services to the teachers, parents or administrators. In crisis situations the counselor may go through the consultative steps in a matter of seconds (Schmidt & Medl, 1983). In everyday practice many counselors are confused about their role as consultant and crisis interventionist. This confusion appears to be due to the counselors' lack of training (Umansky & Holloway, 1984).

Assessment of the seriousness of suicidal ideation is one of the most important tasks of a crisis interventionist and was addressed in both training models cited in the literature. Capuzzi (1986), Martin and Dixon (1986), Miller (1985), and Slaikeu (1984) all emphasize how important it is for interventionists to ask the appropriate questions.

They also are clear as to the necessity of suicide interventionists to be trained in the assessment of suicidal ideation. Related to this issue is the importance of assessing lethality and the availability of lethal means such as guns and drugs. An effective interventionist is knowledgeable about drugs as related to lethality.

Capuzzi (1986) reports the importance of an interventionist serving as a crisis manager. In this role it may be necessary for the counselor to take charge and be direct in taking steps to insure a client's safety.

The importance of the legal issue was reviewed (Fujimura et al., 1985). Emphasis was placed on knowing when to refer clients to more highly trained professionals and of the importance of training in suicide prevention and intervention -- in order to avoid lawsuits.

Neither of the training programs reviewed in the literature included all of the components discussed in this chapter. However, the programs did include: selected readings, bibliographies, an overview of youth suicide, causes of youth suicide, assessment of suicidal risk, crisis intervention, organizational strategies for suicide prevention, enlisting family support and mobilizing the peer system. Didactic presentations were combined with experiential activities. Films and audio tapes were also employed in the various presentations.

For the writer's particular school setting, several solutions were suggested by the literature; each would involve a different degree of commitment and energy. The first possible solution would be to locate pertinent literature on this subject, disseminate it to the counselors,

encourage them to read it, and then lead discussions with them in small group meetings.

Another possible solution would be to arrange an intensive workshop for the counselors in suicide awareness and suicide crisis intervention. This would, by itself involve more training than most of them have received thus far. It would certainly be better than doing nothing, although it would not be nearly as thorough as those programs reported in the literature.

A third possible solution which appears to have merit is to organize a series of workshops with invited presenters on consultation, the role of the counselor in crisis intervention, how to assess suicidal potential, how to assess drug lethality, and legal implications. In-house follow up meetings could be conducted by the writer to fill in any gaps from the workshops, review established policy and procedures, discuss commercial depression scales, review tapes and related literature, and to participate in an experiential component.

This suggested program would be similar to those in the literature which appear to be good and effective. It would not, however, include the peer system and family involvement components that Heiman et al. (1985) included. Inclusion of these components would go beyond the scope of this practicum and would require more time than is available for implementation.

Description of Selected Solution

The selected solution to the problem was a training program

which included the components listed in the preceding section. The program was aimed at increasing elementary, middle school, and ninth grade counselors' confidence in suicide prevention and suicide crisis intervention. To be specific, the writer organized a series of worshops for counselors. Presenters with expertise in each area were obtained to present workshops on the consultation process as it applies to school counselors, the counselor's role in assessing suicidal potential and crisis intervention -- including in-depth information on depression -- assessing drug lethality, and legal issues. Four different speakers addressed one each of the topics listed above. The writer then conducted a series of in-house follow up meetings to: (1) review established policy and procedures, (2) to familiarize the counselors with commercial scales used to assess depression, (3) to review audio and video tapes and literature on this subject, (4) to sensitize counselors to projective techniques, (5) to participate in an experiential -- role playing -- component, and (6) to fill in any gaps from the first four presentations by drawing on the personal experience of the writer.

The plan entailed having a "kickoff" 2 hour workshop on the consultation process by a presenter who is a recognized authority on this topic. This was followed up one week later by a 2 hour workshop on depression, suicide assessment, and suicide crisis intervention. The presenter was a psychiatrist, who specializes in adolescent psychiatry, with extensive experience in this domain. The third presenter was an in-house one. She presented on drugs and assessing drug lethality as part of the crisis intervention

process. She is the district's student assistant person for those with drug and alcohol difficulties, holds a Master of Social Work degree and is recognized state-wide as authoritative on this topic. The fourth presenter, on legal issues in crisis intervention was the writer's department chairperson who has studied school law extensively and is an adjunct professor of special education at several local colleges. The writer then conducted what was, for the most part, bi-weekly follow up meetings to the presentations described here.

It should be noted that no attempt was made to train the counselors in projective techniques. The goal was simply to sensitize the counselors to recognize violent themes in children's drawings which, in the writer's experience, have been visual signs of those who may be suicidal.

This solution, as established previously, did not include family and peer system components as one program in the literature does (Heiman et al., (1985). It did, however, include components cited in the literature but not in the examples of training programs. These include presentations on projective techniques, legal issues, and depression assessment scales. It is believed that these components addressed a local need and added up to a thorough program which may be of interest to other professionals on a wider scale. The solution was expected to address each of the writer's objectives for this practicum.

It was definitely expected to be a better solution than the first suggested one -- that in which pertinent literature is disseminated and discussed with counselors. This approach had been tried previously and although it was discovered to be extremely

helpful, did not go far enough. The second possible solution had been attempted in part. While the counselors had not participated in crisis intervention training, they did have presentations on suicide awareness. Again, while these programs were helpful, they did not go far enough. Thus, the selection of the third solution was appropriate. It addressed the needs more completely and professionally.

Engen (1977) has reported that while there is an evergrowing need for new knowledge and skills among counselors, there are few organized efforts to meet these needs. This practicum addressed these concerns.

The solution began during the first week of February, 1988. The program had the full support of the writer's department chairperson and also of the respective principals at the middle school and high school. The district's ninth graders are housed in the high school which explains the necessity of securing the high school principal's cooperation. The first two meetings were held at the high school and subsequent meetings were held at the special services office complex. Rooms of sufficient size were reserved. Speakers were contacted and were available on specified dates. Remuneration for the first two presenters came from the school system and was approved. The other presenters were in-house and no fees were required.

The implementation proceded smoothly and as planned, for the most part. Some segments of two audio tapes had to be eliminated,

due to time considerations, but these were not considered to be essential to the program. The remaining planned activities were included. Legal issues and the school district's policy required much more time than anticipated -- approximately one hour more than the 1½ hours alloted -- and there was a good deal more discussion than had been expected. The planned topics were addressed, however, by extending the last four sessions by about an hour. Fortunately, the writer had this flexibility. The presentation on projective techniques also aroused much interest as did the writer's private tape of a group of teenagers discussing the recent suicide of a classmate.

The majority of the counselors attended all of the sessions, although three counselors each missed a single session. Implementation was completed on April 21, 1988.

CHAPTER V

RESULTS, CONCLUSIONS AND RECOMMENDATIONS

Results

Upon termination of the workshops each participant was requested to complete a questionnaire (see Appendix B). The questions on the questionnaire were designed to elicit information on each objective and, hopefully, confirmation that the objectives had been achieved successfully. Completed questionnaires were collected from each of the 12 workshop participants and results were compiled in tabular form. In each of the tables (Tables 1, 2, 3 and 4) the first question is the single question which directly assesses the objective, and is also the only question used to determine whether or not a specific objective has been achieved. The purpose of the other questions was to gain additional insights into the objective under consideration. For each objective the standard of performance was that 50 percent, or at least 6, of the participants would answer affirmatively the single question which directly addresses that objective.

The first objective was that counselors would develop a more definitive idea of their role in suicide crisis intervention. As Table 1 clearly shows, all of the participants indicated that they now have a clearer idea as to their role in a crisis situation where suicide, or its possibility, is a concern. Therefore, it is evident

Table 1

Questions and Responses for Objective 1

Question	Responses
1. *Did the program help you to develop a more definitive idea about your role in suicide crisis intervention?*	12 YES 0 NO
2. *Do you have a better understanding of the district's policy and procedures regarding suicide intervention?*	12 YES 0 NO

the standard of performance for the first objective was met. Also, related to this objective, one of the major tasks of one of the workshops was to review, discuss, and clarify the school district's policy and procedures on suicide intervention. In a related question, all of the counselors indicated that they now have a better understanding of the policy.

The second objective was that counselors' confidence in their ability to recognize the signs of suicide would increase. Responses

Table 2

Questions and Responses for Objective 2

Question	Responses
3. *Do you now have more confidence in your ability to recognize the signs of suicidal intent in your counselee?*	12 YES 0 NO

(Table continues)

Table 2

Questions and Responses for Objective 2

Question	Responses
4. *Did the program help you to better understand depression and the signs of depression?*	10 YES 2 NO
5. *Do you now feel more confident in your ability to assess depression in your counselees?*	10 YES 2 NO

to the first question in Table 2 reveal that all of the counselors now have more confidence in this area. Again, it is evident that the standard of performance for the second objective was met. It is also evident that 10 of the 12 respondents gained confidence in their ability to recognize, understand, and assess depression--probably the single most important sign of suicide.

The writer believes that the number of affirmative responses would have been even greater if not for the fact that three counselors missed single workshop sessions. One of the counselors indicated on the questionnaire that he or she could not answer questions five and six because he or she missed the session which addressed this subject. It is believed that, if not for the three absentees, the overall number of affirmative responses would have been higher.

The third objective was that there would be an increase in

counselors' confidence to assess suicidal potential, or ideation, when signs are evident. As indicated by Table 3, 10 of the 12 counselors stated that they now have more confidence in their ability to assess the suicidal ideation of their counselees. Thus the third objective was also met.

Table 3

Questions and Responses for Objective 3

Question	Responses
6. *Do you now have more confidence in your ability to assess the seriousness of suicidal ideation in your counselees?*	10 YES / 2 NO
7. *Are you more clear as to when to refer a counselee directly to an outside agency and when to ask for child study team assistance?*	11 YES / 1 NO

A related issue was that counselors often made referrals to the child study team when referral to an outside therapist or agency, would be more appropriate. All but one stated that they now have a better idea concerning when and to whom referrals should be made.

The fourth objective was that counselors' confidence in their ability to intervene in and manage a suicidal crisis would increase. The figures in Table 4 show that 10 of the 12 participants now have more confidence in their ability to manage a suicidal crisis. It is clear that the standard of performance for this objective was met.

Table 4

Questions and Responses for Objective 4

Question	Responses	
8. *Would you now feel more confident in managing a suicidal crisis for a counselee?*	10 YES	2 NO
9. *Concerning the counselor as consultant, do you now have a clearer idea about the role of a consultant?*	11 YES	1 NO
10. *Has your knowledge of drugs and drug lethality increased?*	11 YES	1 NO
11. *As a result of the program, would you now be more likely to manage a suicidal crisis without requesting help -- of other counselors or child study team members?*	5 YES	7 NO

Questions in this table also address two of the skills necessary for a competent crisis manager -- knowledge of their role as a consultant and knowledge of drugs, alcohol and the related issue of lethality. All except one of the respondents indicated that their knowledge in these areas has increased.

The last question in Table 4 is an interesting one in that it was the only one in the questionnaire to elicit more negative than affirmative responses. The question was included because the writer believed that "yes" answers would indicate increased counselor confidence in this skill. It does appear that this is true for the five participants who responded in the affirmative. However, the fact that seven counselors selected the "no" response does not necessarily indicate that they do not have increased confidence in this area -- especially considering the responses to the first question in Table 4. Their answers appear to be more closely related to information presented in the workshop sessions, in which the value of consultation with another professional was emphasized -- in very serious situations or when doubt is present.

Overall, the workshops were received more positively than the writer had hoped or expected. <u>All</u> of the participants stated that the program had value to them as professionals and <u>all</u> stated that they would like to have more inservice programs of this nature in the future. Their suggestions of topics for future workshops is included in Appendix C. Also unexpected was the counselors' positive comments to the Director of Pupil Personnel Services who

is the administrator in charge of counselors and child study team members. Their comments were so positive that he is making plans to have speakers come in on a quarterly basis. The counselors' likes, concerns, and other comments about the program are included in Appendix C. There have been far fewer referrals to the writer for suicidal students since the program was initiated. In fact, overall referrals have diminished in number. However, it is too soon to tell if this is a trend or merely happenstance.

Two unexpected things happened which were not positive and also not totally unexpected. The first was that one of the counselors was actively contemplating suicide during the program. However, this person had also experienced suicidal ideation prior to the program and fortunately was under the care of a psychologist throughout. In fact the counselor's post workshop discussion with the writer and his/her private psychologist appear to have helped, since the individual is no longer suicidal.

Also unexpected was that, twice, at least three of the counselors came to the meetings approximately 20 minutes late. The reason was that they were actively involved with potentially suicidal counselees and could not leave them. On the other hand, these problems reinforced the timeliness of the program.

Conclusions

The series of workshops on suicide crisis intervention was well attended and well received. As stated previously, the counselors' comments were so positive that it appears that there will be an

ongoing series of workshops -- on various topics and on a quarterly basis.

All of the standards of performance for the four objectives were met. What this means is that the district's counselors now have more confidence in their ability to recognize the signs of suicide, to assess the seriousness of suicidal ideation, and to manage a suicidal crisis. Overall, they now have a better understanding of their expected role in suicide intervention. This takes on added meaning when it is realized that the counselors are presently better trained and are more likely to be able to save a human life.

On one hand, the counselors profess increased confidence in their ability to manage a crisis while, on the other hand, a majority indicate that they would seek the advice of another professional when they are not sure of the appropriate step to take. The writer believes that this is the manner in which a professional counselor should act.

Recommendations

1. Anyone who conducts a series of workshops, similar to the ones described in this practicum, should probably allot more than the 12 hours planned for by the writer.
2. Meetings were held away from the counselors' assigned schools, although the director of counseling was available for any emergencies. This distance from the workplace would be essential to the success of any program because it diminishes the chance of interruptions.

3. *Elements of this "solution" should be extended to the students. They should be able to recognize the signs of suicide and realize that they have a potential role to play concerning their friends and peers.*
4. *The counselors, now trained in the basics of suicide assessment and intervention, could form a corps of trainers to work with students.*
5. *In approximately a year, a follow up study should seek to determine whether or not there has been a decrease in referrals to the child study team.*

Plan for Dissemination

The writer will personally discuss the results of this practicum with, respectively, the directors of pupil personnel services and counseling, and also with the assistant superintendent of schools. Members of the district's child study team will receive copies of the abstract and will be extended an opportunity to discuss the results. Workshops of this nature will be made available, by the writer, to the local county counselors' association and to the county special services department in which the writer resides.

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APPENDIX A

SUICIDE POLICY

STUDENT SUICIDE INTERVENTION POLICY

The Board of Education, along with school administrators, teachers, and staff, always strives to provide the best possible, academic, social and communal environment for its students.

They are aware of the need to develop and effectuate policies and practices that will enable employees to utilize uniform guidlines and procedures in dealing with students who have shown self-destructive tendencies.

PROCEDURE

I. Secondary and Elementary Schools

A. The professional staff member who has reason to believe that a student has self-destructive tendencies shall notify the school counselor.

B. If, after meeting with the student, the counselor deems the situation to be serious but not a crisis (for example, if the student says, "I sometimes think about killing myself") the counselor shall:

1. Contact the student's parents by telephone and in writing, and recommend that a mental health professional be consulted; and

2. Provide to the parents, if requested, the names of mentalhealth agencies and/or private therapists; and

3. Notify the psychologist and/or social worker normally assigned to that school, and consult on an as-needed basis with the psychologist; and

4. Notify the Director of Guidance of the incident; and

5. Maintain a written log of the student's behavior and actions while in attendance during regular school hours.

C. If, after meeting with the student, the counselor deems the situation to be a crisis and believes the student to be in imminent danger (for example, if the student says, "I'm going to kill myself today"), the counselor shall:

1. Keep the student under continuous adult supervision; and

2. Contact the psychologist responsible for suicide crisis intervention who shall as soon as is practicable:

a) consult withthe student and counselor; and

b) contact the student's parents and ask them to come immediately to the school; and

c) recommend to the parents a referral to a mental health agency or therapist; and

d) notify the building principal and apprise him/her of the situation.

D. The school principal will notify the office of the superintendent.

E. If the student is in the process of attempting suicide or has already made an attempt, the building principal or assistant principal will contact the police and other emergency personnel as needed.

II. <u>Additional Guidelines</u>

A. Parents should always be notified when suicidal tendencies have manifested themselves, as when suicide is threatened or attempted.

B. No professional staff member should hesitate to take the steps outlined in this policy, based upon the mistaken belief that to do so would constitute a breach of trust.

C. Any student deemed to be in imminent danger should have continuous adult supervision during the school day and until such time as the parents regain custody.

D. The psychologist or social worker assigned to a particular case in which suicidal tendencies are suspected or discussed will normally stay with that case until its conclusion. However, the district psychologist assigned to suicide crisis intervention will be available for consultation and should be contacted when there is imminent danger.

E. If the crisis intervention psychologist is not available, the social worker or psychologist normally assigned to the building should be contacted.

F. The school social worker may, at times, have an important role in the entire process and should be viewed as a consultant by the professional staff. This may be especially true where involvement with the family is required.

G. When a student has actually attempted suicide, it is appropriate to keep the student out of school until proper medical documentation can be secured.

H. <u>All</u> staff members should document any and all involvement in these cases.

I. If there is absolutely no way for the parents to come to the school, the principal will assign the school nurse to transport the student home.

J. The building Principal will continually monitor the follow up activities of each case of "imminent danger".

It will be that principal's decision to invoke Policy JHCDE (Child Abuse) in the event that counseling recommendations are not implemented.

Public Schools
Special Services Department
WASHINGTON SCHOOL
1641 Avenue

Area Code
662 8500

Frederick Keating
Director of Special Services

June 17, 1988

To Whom It May Concern:

Please be assured that Wayne Culp has permission to use the District's suicide policy as he sees fit.

Sincerely,

Frederick Keating
Director

FK/cw

APPENDIX B

QUESTIONNAIRE

QUESTIONNAIRE

Directions: These questions are based on the recent series of workshops on youth suicide in which you participated. Please answer each question by circling the response which applies to you.

1. *Did the program help you to develop a more definitive idea about your role in suicide crisis intervention?* Yes No
2. *Do you have a better understanding of the district's policy and procedures regarding suicide intervention?* Yes No
3. *Do you now have more confidence in your ability to recognize the signs of suicidal intent in your counselees?* Yes No
4. *Did the program help you to better understand depression and the signs of depression?* Yes No
5. *Do you now feel more confident in your ability to assess depression in your counselees?* Yes No
6. *Do you now have more confidence in your ability to assess the seriousness of suicidal ideation in your counselees?* Yes No

7. *Are you more clear as to when to refer a counselee directly to an outside agency and when to ask for child study team assistance?* Yes No

8. *Would you now feel more confident in managing a suicidal crisis for a counselee?* Yes No

9. *Concerning the counselor as consultant, do you now have a clearer idea about the role of a consultant?* Yes No

10. *Has your knowledge of drugs and drug lethality increased?* Yes No

11. *As a result of the program, would you now be more likely to manage a suicidal crisis without requesting help -- of other counselors or child study team members?* Yes No

12. *Overall, did the program have value for you as a professional?* Yes No

13. *Please list your likes and concerns about the program.*

LIKES

CONCERNS

14. *What aspects of the program were the most helpful/useful to you?*

15. *What was the least helpful/useful?*

16. *In the future, would you want to participate in more inservice programs of this nature on other topics?* *Yes* *No*

17. What topics would you want to see addressed?

APPENDIX C

ADDITIONAL COUNSELOR COMMENTS ON THE PROGRAM

A. Likes

1. Interchange of ideas.
2. One of the few inservice programs designed for counselors.
3. It directly addressed the problems with which we are dealing in a school system.
4. Handouts were informative and helpful.
5. Everything was important!!
6. Very imformative.
7. Presentation was thorough and contemporary.
8. Format (discussion and interaction) was very good.
9. Small group - Informal setting and exchange.
10. I have a better scope of the problem.
11. The atmosphere was relaxed, encouraging group discussions and individual sharing.

B. Concerns

1. We should have a more specific, clearly defined policy which offers protection to parents.
2. Would like more sessions!!

C. What aspects of the program were the most helpful/useful to you?

1. Interaction with other counselors.
2. The discussions, case stories, and readings.
3. All were helpful.
4. Suggestions and step by step procedures for crisis intervention.
5. Updated literature, sources and information.
6. Written review of the literature on youth suicide.
7. Experiential knowledge shared by others.
8. Scales on depression, etc.

D. What was least helpful/useful?

1. . Going over the policy - It is inadequate as it stands.

2. Handouts.

E. Suggested Topics for Future Inservice Programs

1. Teen pregnancy
2. Counseling urban students
3. Child abuse
4. Death and Dying
5. AIDS
6. Drugs and alcohol - more on suicide
7. Incest
8. Rape crisis counseling
9. Family counseling
10. Divorse and separation
11. Adolescents and the occult
12. Disaffected students
13. Legal aspects and confidentiality
14. Managing multiple priorities
15. The consultation model
16. Coping skills for children
17. Helping children to develop support systems